The Role of Quality in Behavioral Health Managed Care

July 11th, 2016

Role of External Quality Review

- **Assist the DHHS in overseeing Medicaid Managed Care**
  - Independent agency that works collaboratively with DHHS to ensure that the best care is provided

- **Evaluate MCOs' capability to ensure quality of, access to and timeliness of care**

- **Partner with MCOs to further the common aim of continual quality improvement**

Components of External Quality Review

- **Compliance Review**
- **Performance Improvement Projects**
  - MCOs to conduct 1 non-clinical and 2 clinical PIPs, 1 of which must address a behavioral health concern
- **Performance Measurement validation**
- **Annual MCO Technical report**
- **Training and support**

Quality of Care

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*

Successful behavioral health care requires:

- Meeting an individual's needs
- Integrated services
  - Primary care
  - Specialty mental health care
  - Substance abuse care
  - Community –based support care

*Institute of Medicine Quality Improvement in Behavioral Health 1997

Heritage Health Facilitates Successful Care

Addresses the health care needs of the whole person

- Early identification of healthcare needs to ensure appropriate level of care
  - Aim to reduce readmissions and ER visits
  - Coordination begins once needs are identified
- Social determinants are integrated
- Community resources are identified to facilitate referrals

Heritage Health Promotes Integrated Care

- Services are integrated
  - Physical health, behavioral health, pharmacy
- Integration will improve coordination and communication and reduce fragmentation
  - Members with both behavioral/physical needs will receive full continuum of care
- Integration facilitates monitoring to ensure goals are met
  - Data exchange is minimized and data capture improved

Heritage Health Engages Stakeholders

- Enhances transparency
  - Stakeholder input is encouraged
- Behavioral Health Integration Committee
  - Transition
  - Care continuity
  - Advise State and MCOs on best practices for integration
- Quality Committee
  - Measurement
  - Improvement initiatives

Nebraska Quality Strategy for Heritage Health

Improve the health and wellness of Medicaid clients by increasing access to comprehensive health services in a cost-effective manner.

Goals include:

- Improve health outcomes
- Expand access to high quality care
- Enhance integration and quality
- Person-centered care
- Reduce costly avoidable care
- Increase evidence-based treatment
- Recovery-oriented system of care

Nebraska Quality Strategy is Aligned with CMS National Quality Strategy

CMS Quality Strategy Fact Sheet

Uncoordinated Care is Costly and Undesirable for Patients

IOM Goals of Managed Care:

- Ensure quality, effectiveness and access
- Cost control through efficiency and coordination, which improves access and quality
- If we really focused on patient/client-driven, assessment based, clinically-driven treatment in the most efficient and effective way, based on accountability and data, that would take care of costs*

*IOM 1997; David Mee-Lee ASAM

Drivers of Quality in Managed Care

External Drivers

- State and Federal Oversight
  - State Quality Toolkit
- State MCO contracting
- National Performance Indicators (e.g., HEDIS)
- Competitive Market

Internal Drivers

- Accreditation
- Quality leads to efficiency
  - Goal is not cost containment but quality reduces costs

Heritage Health Quality Drivers

- MCO requirements include:
  - Comprehensive reporting on broad range of nationally recognized measures
  - Active care management
  - Maintenance of robust provider networks
  - Integration of social determinants of health
  - Provider support
  - Member engagement and protection
- Reporting will inform quality improvement initiatives
- Heritage Health Quality Committee central to measurement and improvement

Heritage Health Quality Drivers (cont.)

Institute value-based payment

- Performance goals tied to financial incentives
  - Metrics targeted to needs of Medicaid patients
- Payment based on:
  - Accountability for making improvements in health outcomes, care quality, or cost efficiency
  - Alignment of providers' financial and contractual incentives with those of the health plan.

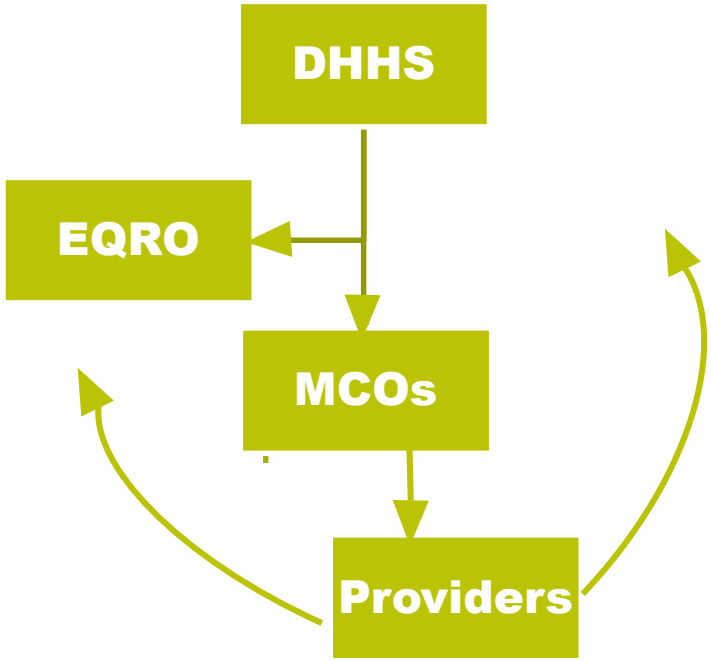
Characteristics of a Successful MCO Quality Program

- **Heritage Health Quality Strategy includes Measurement and Improvement Standards-Maintaining an ongoing QAPI Program**
- **Quality Improvement Programs should include:**
  - Well-articulated mission and defined goals
  - Active management support and engagement
  - Quality committees
- **Structure and accountability**
  - Defined roles responsible for maintaining quality
  - Quality embedded in routine MCO operations
  - Coordination among departments

Characteristics of a successful MCO Quality Program continued

- **Provider credentialing**
  - Process of selecting/verifying practitioners access to best providers in networks
- **Focus on continued improvement**
- **Data driven**
  - Metrics to monitor performance and satisfaction
  - Performance Improvement Projects to address structural and process weaknesses
- **Resources adequate to meet the quality objectives**
- **Trending of findings over time**
- **Care Management program to coordinate care**

Assessing Quality in the Managed Care System-Quality Improvement



Quality assurance: focus on identifying outliers
Quality improvement: improving means, continued improvement

Questions?

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